STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REHAB CTR OF SPRINGWOOD	5755 SHATTALON DRIVE WINSTON-SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 170 SS=D	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with facility staff and residents, the facility staff opened resident mail prior to delivering the mail to the resident for 2 of 3 sampled residents. (Resident #9 and Resident #63) The findings included: Record review of the policy titled " Resident Mail " updated 5/20/14 revealed in part, " If the mail being received and addressed to the resident is believed to be a check, the mail should be delivered to the resident unopened. The facility representative that delivers mail, generally activities, should ask resident to open in their presence to verify. If there is a check, then resident is referred to Business Office to secure funds. " Resident #63 was admitted to the facility on 12/18/12. The most recent quarterly Minimum Data Set (MDS() dated 6/25/14 coded Resident #63 with a BIMS (Brief Interview for Mental Status) score of 13 which indicated she had no problem with short or long term memory. Observation and resident interview on 7/14/14 at 3:25 PM revealed Resident #63 was holding an	F 170	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action: Resident #63 received a visit from the facility Administrator on 07/15/14, apologizing for the breach in privacy and assuring her that it will not happen again. Resident #9 received a visit from the facility Administrator on 08/01/14, apologizing for the breach in privacy and assuring him that it will not happen again. Identification of other residents who have the potential to be affected by this practice: All residents have the potential to be effected by this alleged practice. Facility Policy regarding Resident Mail will	8/9/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/10/2014

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F 170	Continued From page 1 envelope that had just been delivered to her. The envelope was from the bank and had been opened. Resident #63 said, " Look at this. My mail was opened. The receptionist had just delivered the piece of mail from a bank and it was opened. " Interview with Resident #63 on 7/14/14 at 3:30 PM revealed that she questioned the receptionist as to why her mail was opened and Resident #63 said that the receptionist told the resident that she thought there was a check in envelope. Resident #63 revealed that she did not like it one bit that her mail had been opened. There was no check in the envelope. Resident #9 was admitted to the facility on 1/27/14. The most recent quarterly MDS dated 4/26/14 revealed that the resident had a BIMS score of 15, indicating he had no problem with short or long term memory. Interview with Resident #9 on 7/16/14 at 11:30 AM revealed that he had a piece of mail opened before he received it. He received and personal letter that the receptionist opened. Resident #9 revealed that he did not like it because it was none of her business. Interview on 7/15/14 at 1:50 PM with the receptionist revealed that it looked like there was a check in the envelope. She continued that when she received resident mail from a bank or when she thought there was a check in the envelope, she opened the mail and then put the check in the resident ' s trust account and then notified the resident. The receptionist reported she did not open mail unless it was a check (sees it through the window) or if the envelope was from a bank. The receptionist continued that when she	F 170	be reviewed at the next Resident Council Meeting, to educate the residents on their right to privacy. If they receive mail that has been opened, they are to report this to facility Administrator as soon as possible for follow-up. Systemic Changes: On 07/15/14, an inservice was conducted by facility Administrator regarding the policy for Resident Mail. Full and Part Time Receptionists, Medical Records, Admissions, Activity Director and Social Services Worker were inserviced. Activities Director or designee will monitor mail during delivery to ensure that nothing has been opened. If any mail is discovered opened, Activities Director will report immediately to Administrator for investigation and follow-up. Monitoring: To ensure compliance the Social Worker or her designee will conduct an interview using the QA Mail Delivery Tool with three residents to verify that the mail they received was unopened. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to Administrator or DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 170	Continued From page 2 opened the envelopes, the checks were deposited in the resident trust account. It has always been done that way for the past 6 years. Interview on 7/15/14 at 1:55 PM with the Business Office Manager revealed that she did not know anything about the mail delivered opened or unopened. Interview on 7/15/14 at 2:00 PM with the social worker revealed that it was a resident right not to have their mail opened. The social worker said the receptionist should know resident rights. The resident has a right to open their own mail. Interview with the Administrator on 7/15/14 at 4:05 PM revealed that it was not facility policy to open resident mail.	F 170		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews the facility failed to encourage and provide an ongoing program of activities for 1 of 1 cognitively impaired resident reviewed for activity program participation (Resident # 151). Finding included:	F 248	Corrective Action: The family of Resident #151 was interviewed by Activities Staff regarding her preferences on 08/07/14. A participation log has been keep on all attendance in Activities programs or in room activities. These are recorded in POC (Point of Care) Activities tasks. The Activities Director was counseled by the	8/14/14

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F 248	Continued From page 3 Resident #151 was readmitted to the facility 5/28/14 with diagnosis of dementia, hypertension and diabetes. Review of the (MDS) Minimum Data Set Assessment with an assessment reference date of 6/4/14 indicated that Resident #151 required extensive assistance with activity of daily living and was severely cognitively impaired. The staff assessment of activity preference revealed that Resident #151 enjoyed listening to music and spending time outdoors. The care plan dated 6/25/14 indicated an intervention for activities department to provide activities that are meaningful. During an observation on several occasions during the day on 7/14/14, 7/15/16 and 7/16/14 revealed Resident #151 in the room sitting in the wheelchair with no in room activity. During an interview on 7/15/14 at 1:45 PM with a family member of Resident #151 revealed that there are no activities offered. Resident #151 is never taken out of the room and no one comes to room for an in room activity. She further stated that family visits everyday and is involved with Resident #151 ' s daily care. An interview with the Activity Director on 7/17/17 at 10:00AM revealed that she offers in room visits for Resident #151 but it is not documented on the participation log. She further indicated that when Resident #151 does come to music or outside activities that she does not stay long. There was no available documentation for the month of July 2014 that indicated that Resident #151 refused to participate or that she received any one to one	F 248	Administrator on maintaining up to date participation records. Identification of other residents who have the potential to be affected by this practice: All residents have the potential to be affected by this alleged practice. The Administrator reviewed the participation logs for all residents from July 17th (the date of survey) through July 31st to identify any residents that did not attend at least 1-2 activities a week including in room visits. This review revealed that 30 residents had not attended at least 1-2 activities. These residents were interviewed for current preferences and activities scheduled to meet their needs. Systemic Changes: On Admission, Quarterly and with Significant Change an interview is conducted to ensure activities offered are meaningful and that they meet the needs of the residents. This is documented through MDS, care plans or Activities progress notes. The Activities Director will track attendance and document participation in the computer system. Any resident that continues to refuse activities will be care planned accordingly. Monitoring: To ensure compliance the Unit Manager or her designee will conduct an interview using the QA Survey Tool with three residents to verify that were offered activities. Review of the participation log in the computer will be completed on three residents to ensure participation is documented. This will be	

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F 248	Continued From page 4 visits from facility activity staff. Review of the activity participation log for the months of May, June and July 2014 revealed 6 days of participation in the month of June 2014.	F 248	done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to Administrator or DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and interview with the mattress manufacturer representative, the facility failed to maintain the setting of the Low Air Loss Mattress as recommended according to the resident ' s weight for 1 of 3 residents (Res. # 45) observed with the presence of advanced Pressure Ulcers. Findings include: Resident #45 was admitted to the facility on 2/5/14 with cumulative diagnoses of Multiple	F 314	Corrective Action: The air mattress for Resident # 45 was inflated to resident□s weight and comfort without bottoming out per manufacturer recommendations. The Treatment Nurse was inserviced on 07/17/14 by the Director of Nursing on air mattresses operation, inflation and placement. Identification of other residents who have the potential to be affected by this	8/11/14

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F 314	Continued From page 5 Sclerosis, Diabetes, Contractures of the Ankle/foot Joint, Unspecified Urinary Incontinence, Hyperlipidemia, History of TIA (Transient Ischemic Attack), and Osteoarthrosis. Review of the Admission Assessment of 2/12/14 indicated the resident was at risk for Pressure Ulcers, had a pressure reducing device for the bed and chair, and had no weight loss. The Dietitian Nutrition Admission Assessment of 3/4/14 indicated Resident #45 had Physician ' s orders for a Regular Concentrated Sweets Diet and a (High Protein Supplement) of 30 cubic centimeters twice a day. The resident had a height of 67 inches, and a weight of 182.4 pounds. Risk indicators included a 27-29 Basal Metabolic Index, an Albumin level of 3.9, and Skin issues: Stage II Sacrum. Nutritional risk related to resident with a wound. Nutritional Goals: Weight will remain stable, wound will heal and skin will remain from further breakdown. Recommendations: By mouth intake of 76-100%. (High Protein Supplement) is beneficial for wound healing. Review of the Physician's order on 5/1/14 read: Air mattress for prevention-check function and placement. The Current Care Plan of 6/1/14 indicated the Focus was : At risk for pressure ulcer development due to bowel and bladder incontinence, decreased ability to assist with repositioning, decreased sensation related to Diabetes, Peripheral Neuropathy, Multiple Sclerosis and refusal to limit time out of bed in the wheelchair. The resident has a pressure area on the sacrum. Interventions: Apply moisture	F 314	practice: All residents on air mattresses have the potential to be affected by this alleged practice. Air mattresses were checked by the Director of Nursing, unit manager and central supply clerk for proper inflation to weight and comfort without bottoming out. The results of this audit revealed four air mattresses identified not inflated to manufacturer□s recommendations. Systemic Changes: On 08/06/14, Nurses, Med Techs and Nurse Aides were in-serviced on Wound Prevention. Wound Care topics included the proper inflation to weight and height without bottoming out and care and operation of the air mattresses. Any issues identified with inflation of an air mattress are to be reported to the nurse who will assess and make appropriate adjustments and notify maintenance or central supply as needed. This information has been integrated into the standard orientation training and in the required in-service. Monitoring: To ensure compliance the Director of Nursing or her designee will conduct a review using the QA Wound Survey Tool observing three residents with air mattresses. The items reviewed will include TAR (Treatment Administration Record) for documentation that air mattress was in place inflated and functioning, followed by observation of the resident for support surface for inflation to weight without bottoming out and positioning. This will be done five times per week for four weeks then monthly for	

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F 314	Continued From page 6 barrier with each brief change and as needed. Assist with frequent position changes and turning for pressure reduction and comfort. Encourage resident to shift weight frequently when sitting up in chair. Encourage resident to limited time out of bed, Low air loss mattress on bed, provide incontinence care as needed, report to nurse immediately if note : redness, open areas, irritation to skin, treatment as ordered and use maxi slide /draw sheet to aid with positioning in bed in order to reduce friction/shearing. Nutritional Progress notes by the Registered Dietitian dated 7/11/14 read: Resident seen re: wound. (The resident) has a stage III coccyx. Receiving a high protein supplement 30 cc (cubic centimeters) BID (Two times per day) to assist with wound healing. PO (by mouth) intake: 76-100%. Last documented wt.(weight) on 6/27/14 at 180.2 #(pounds) which is stable 30,90 days and since admission in February. Will continue to monitor. Interview with the treatment nurse on 7/17/14 at 9:00 AM indicated pain medicine was given and the wound care doctor debrided the resident ' s wound on Tuesday (7/15/14). The nurse indicated, " The resident got this wound on June 18, 2014. I treated it and it was better measurements of 2.1 cm (centimeters) x 0.8 cm x 0.4 cm. The measurements on 7/15/14 were 2.8 cm x 3.0 cm 100 % necrotic. The wound doctor debrided it on 7/9/14 and 7/15/14. The resident was already on the low air loss mattress before the resident got this wound. (The high protein supplement) was ordered on 6/14/14. Treatment observations on 7/17/14 at 9:45 AM indicated the treatment nurse, assisted by NA #1,	F 314	three months. Identified issues will be reported immediately to Administrator or DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 314	Continued From page 7	F 314		

cleansed the wound with Normal Saline. Santyl ointment was imbedded in the wound and lightly packed with CA Alginate and a dry dressing was applied. The low air loss mattress was observed set for 400 pounds.

Observation on 7/17/14 at 8:30 AM and 10:00 AM indicated the resident ' s low air loss mattress was observed set at 400 pounds. The setting ranges on the box at the foot of the bed ranged from a setting of soft, 80,120,160,200,240,280,320,360, and 400 pounds.

According to the Weight Summary the resident ' s Height was 67 inches. The current weight on 6/27/14 was 180.2 pounds (weighed with use of a mechanical lift scale). The weight history included: 6/4/14 at 171.6 pounds, 6/2/14 at 169.2 pounds, 5/27/14 at 176 pounds, 5/13/14 at 177.6 pounds, 5/8/14 at 178.8 pounds, 4/23/14 at 176.4 pounds. The Ideal Body Weight Range was 153-185 pounds.

A staff interview with the Assistant Director of Nurses on 7/17/14 at 10:40 AM indicated, " The weight was just taken and was 178.4 pounds with use of a mechanical lift. "

A review of the Low Air Loss and Alternating Pressure Mattress Replacement System User's Manuel was completed on 7/17/14 at 10:45 AM. The Manual directions indicated, " According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out. "

Interview with the resident on 7/17/14 at 10:50 AM indicated the resident was comfortable on the

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F 314	Continued From page 8 low air loss mattress, and not sinking to the bottom of the mattress. A staff interview was conducted with the Treatment Nurse on 7/17/14 at 11:00 AM. When asked if she assessed the resident about the inflation of the mattress, the Nurse indicated, "I don't know anything about the settings. I just write the order to check function and placement. I just found out today about the settings from the Staff Development Nurse. The resident has had the low air loss mattress on the bed since 5/1/14." A staff interview was conducted on 7/17/14 at 11:10 AM with the Director of Housekeeping who originally set up the resident's low air loss mattress The Director of Housekeeping indicated, " I place them (referring to the low air loss mattresses) and start it, and the nurses are supposed to check behind me. The former Treatment Nurse was supposed to check the mattress behind me." Interview on 7/17/14 at 1:30 PM with the Staffing Coordinator /Supply Clerk indicated it was her role was to place the low air loss mattresses on the beds. When asked if she set the settings and what procedure was followed. The Staffing Coordinator indicated "The wound care nurse let's me know who needs to be put on an air mattress. I go in the Point Click Care System and I look up the resident's weight, and I adjust the settings on the box according to their weight. The box has weight settings." When asked if she was aware of why resident #45 ' s setting was at 400 pounds, the Staffing Coordinator stated, "I do not know how that could have happened, unless someone could have bumped it or unplugged it. If you unplug it, it automatically goes to the 400 lb.	F 314		

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F 314	Continued From page 9 setting. I'm pretty sure that's what happened/someone unplugged it." A telephone interview with the former Treatment Nurse was conducted on 7/17/14 at 1:50 PM. When asked what procedure was used for setting up the low air loss mattresses, the former Treatment Nurse indicated, " I would have the mattresses placed by the Director of Housekeeping and then I would check. The main thing you would check for would be the proper weight for the resident on the setting on the box that hooks to the air mattress via the hose from the box to the mattress." When asked what setting was used for resident # 45. The nurse indicated, " the setting would have been based the resident ' s weight. " When asked about a setting of 400, the nurse stated, "It was not a proper setting unless the resident had gained a lot of weight." Additional observations on 7/17/14 at 2:00 PM 2:30 PM, 3:00 PM, and 3:30 PM, indicated the setting remained on 400. An interview on 7/17/14 at 2:10 PM the facility purchasing analyst indicated, "Those low air loss mattresses are set by the resident's weight. It's digital and the setting goes up or down based on the patient's weight. When asked about a dial setting of 400, the purchasing analyst stated, " That setting would be for somebody who's weight was up to the capacity of somebody that falls between 360 pounds - 400 pounds." A staff interview conducted with the current Treatment Nurse on 7/17/14 at 2:45 PM indicated the resident had a history of pressure ulcers on the sacrum or coccyx since April of 2014.	F 314		

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F 314	Continued From page 10 An Interview on 7/17/14 at 3:10 PM with the low air loss mattress manufacturer representative indicated, "The settings are based on patient weight. The system also has the option of selecting the frequency with which the cells inflate and deflate with air. A setting of 400 would be a setting to support a person who weighs 400 pounds. " The representative indicated the setting could be increased if the resident preferred a firmer mattress. A Direct Care staff interview was conducted on 7/17/14 at 3:20 PM with the resident's assigned aide (NA#1). When asked if she noticed if the resident's low air loss mattress had been unplugged today (7/17/14) or if she had unplugged it for any reason. The NA stated, "I never unplug it. I never mess with it or the settings. " An interview with the Administrator on 7/17/14 at 3:35 PM indicated the Administrator's expectations were, "That the setting of the mattress should have been a thoughtful process, and I am not sure that the setting was a done through a thoughtful process. " The Administrator also indicated she learned today (7/17/14) if the mattress was unplugged and re-plugged, it automatically set back to 400. The Administrator was unaware whether the mattress had been unplugged or not.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		8/11/14

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F 323	Continued From page 11 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, manufacturer's instructions, resident interview and staff interview, the facility failed to prevent an accident for 1 of 1 sampled resident (Resident #77) whose wheelchair anti-tippers were modified as evidenced by reinforcing anti-tippers with duct tape. The findings included: Resident #77 was admitted to the facility on 9/17/13 with diagnoses including bilateral amputation, congestive heart failure, hypertension and renal disease. The most recent Minimum Data Set (MDS) Assessment dated 5/14/14 revealed Resident #77 required extensive assistance with the use of one person physical assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS further revealed Resident #77 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15. A review of a physical therapy note dated 6/30/14 indicated, "Patient complaint of asymmetric posterior anti tipper of temporary wheelchair thus addressed by adjusting length of shaft through duct tape." A review of Resident #77's care plan revised 7/4/2014 revealed a Focus of, "I am at risk for	F 323	Corrective Action: Resident # 77□s most recent fall was on 07/02/14 with no injuries. The Interdisciplinary team (Nursing, SS, Dietary, Activities and Therapy) reviewed the fall care plan to ensure that the interventions in place were appropriate. A new wheel chair with anti-tippers locked in place per manufacturers□ guideline was provided on 07/03/2014. Identification of other residents who have the potential to be affected by this practice: All residents with a fall intervention of anti-tippers on the wheel chair have the potential to be affected by this alleged practice. The Physical Therapist conducted an audit on 08/07/14 of all residents who have anti- tippers as falls interventions. There were 41 residents who used anti-tippers on either the front or back of their wheel chair. These wheel chairs and anti-tippers were inspected by the therapist and maintenance staff to ensure they were installed per manufacturer□s recommendations. MDS nurse reviewed fall and fall risk Care Plans to assure they were consistent with the anti-tipper interventions in place. The results of the audit revealed all residents with	

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F 323	Continued From page 12 falls related to double amputee, balance issues, weakness from dialysis, antidepressant use and need for lift for transfers." The goal indicated, "My risk of falls will be minimized through current interventions times 90 days." The interventions included; Bed in lowest position, anticipate and meet my needs, I need a safe environment, I need activities that minimize the potential for falls while providing diversion and distraction, I need frequent safety reminders and on 7/2/14 new wheelchair provided. Review of nurses note dated 7/2/14 revealed, "Resident #77 noted lying on her back on the floor between the two beds. No apparent injuries noted and denied any pain" The note continued that Resident #77 was sent out to the emergency room for evaluation. Review of incident report dated 7/2/14 revealed Resident #77 was noted lying on the floor on her back between two beds. During repositioning of the lift pad in the wheelchair, the wheelchair tipped backwards and she slid out. The incident report continued that while Nursing Assistant (NA) #1 was fixing the lift pad the wheelchair tipped back. It was duct taped to the wheelchair in the back. Resident #77 mental status at the time of the incident was identified as oriented to person, situation, place and time. Review of Resident #77's hospital discharge summary dated 7/2/14 revealed she received treatment following a fall and diagnosed with scalp hematoma. Interview with Resident #77 on 7/17/14 at 8:29 am revealed the facility provided her with a loaner	F 323	anti-tippers were installed correctly. Systemic Changes: Therapy department was inserviced on anti-tippers on wheelchairs and correct application per manufacturers recommendations on 7/16/2014 by the Rehab Director. Nursing staff were inserviced on identifying any issues or concerns with anti-tippers placement and/or functioning. If issues are identified, nursing staff is to transfer the resident to another appropriate wheel chair and notify Therapy Department or Maintenance. Therapy or maintenance will inspect the anti-tippers on the wheelchair and ensure safety prior to returning the wheelchair to the resident. Monday through Friday the Clinical QA team will review new falls for interventions including anti-tippers. This falls review will include: Review of incident reports, Nurse Daily Report and Nurses notes to ensure an appropriate intervention is initiated to lessen risk of future falls with injury. If anti- tippers are being utilized for the resident with a fall, the team will check to ensure anti-tippers are installed and functioning properly. Any concerns will be addressed and the Administrator or DON notified. The Daily Clinical Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed. Monitoring: To ensure compliance the Rehab Director or her designee will conduct a review using the QA Survey	

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F 323	Continued From page 13 chair while waiting for the delivery of an ordered chair. Resident #77 indicated the anti-tippers on the loaner chair were dragging on the ground and making it hard for her to ambulate about the facility. The resident indicated that she continued to ask what could be done about the tippers causing her chair to drag. Physical therapy indicated the only way to prevent the anti-tippers from dragging the ground was to put them in further and reinforce the tippers with duct tape. Resident #77 stated she is provided assistance by staff by means of a mechanical lift. Resident #77 revealed that on 7/2/14 NA#1 was attempting to put the mechanical lift pad underneath her. She stated that they got the mechanical lift pad underneath half of her and when she leaned backwards to assist NA#1 with getting the mechanical lift pad underneath her other side the wheelchair went backwards. Interview with NA #1 on 7/16/14 at 3:14 pm revealed Resident #77 was normally on her assignment and was on 7/2/14 (date of incident). On the date of the incident Resident #77 was in a loaner chair. NA #1 revealed on 7/2/14 she was assisting Resident #77 as evidenced by putting the mechanical lift pad under the resident. To assist Resident #77, NA#1 would have resident shift her weight from one side to the other to get the mechanical lift pad underneath her. NA #1 continued that while attempting to position the mechanical lift pad underneath Resident #77, she fell backwards. Resident #77 anti-tippers located to the rear of chair collapsed inward. NA#1 indicated the anti-tippers had duct tape around them. NA #1 indicated she had gotten the nurse to communicate resident #77 had fallen backwards in her chair.	F 323	Tool observing three residents with anti-tippers. The items reviewed will include observation for proper placement (1 ? to 2 inches from floor with lock buttons completely engaged) and function. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to Administrator or DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 323	Continued From page 14 Interview with Physical Therapist (PT) #1 on 7/16/14 at 4:11 pm revealed Resident #77 wheelchair was dumped meaning the posterior is dropped down due to Resident #77 being a double amputee and her center of gravity being misplaced. PT #1 revealed Resident #77 had been approaching PT #1 indicating her anti-tippers were dragging. Due to the wheelchair being dumped and the anti-tippers being one size it caused the anti-tippers to drag. PT#1 stated she pushed the anti-tippers beyond its locking mechanism and reinforced the anti-tippers with duct tape. PT#1 indicated she reinforced the anti-tippers due to the resident ' s request. PT#1 indicated she observed Resident #77's anti-tippers and wheelchair following the incident and the Duct tape on the anti-tippers was still intact. PT#1 had no idea how the wheelchair fell backwards, but did not believe the duct tape contributed to the fall. In a continued interview with PT#1 on 7/17/14 at 1:06 pm she revealed she had explained to Resident #77 that the anti-tippers were needed for her safety due to her amputation. PT#1 indicated she tested the weight of the resident with the modified tilters by tilting the chair back to see if the anti-tippers were sturdy. Duct tape was applied to Resident #77 wheelchair on June 30th, 2014. PT#1 stated the anti-tippers were to delay the fall back not prevent it. Explained to Resident #77 if we pushed the anti-tippers beyond the latch they would not lock. Modifying the equipment was patient request. Review of anti-tipper manufacturer's recommendations provided by director of therapy revealed a section identifying "Adjusting/replacing Anti-Tipper ". The warning	F 323		

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dictated, "Anti-tippers MUST be fully engaged. Ensure the lock buttons of the anti-tippers fully protrudes out of the mounting holes in the anti-tippers brackets." The Section identifying "Adjusting anti-tipper revealed a warning that dictated, "When anti-tippers are used, anti-tippers MUST be adjusted to maintain a 1-1/2 to 2-inch clearance between the bottom of the anti-tipper wheels and the ground/floor. This spacing should ALWAYS be checked whenever adjustments/changes are made to the wheelchair. Failure to maintain proper spacing may result in the chair tipping over backward causing serious injury or property damage."

Interview with Director of Nursing (DON) on 7/17/14 at 2:08 pm revealed modification should only be done according to manufacturer's specifications. Duct taping would not be considered a sufficient practice. Wheelchair safety equipment shouldn't be modified per resident request.

Interview with the rehab director on 7/17/14 at 2:14pm revealed Resident #77 was persistent with wanting her anti-tippers not to drag and wanting them raised. Physical therapy exhausted all options in regards to satisfying the resident's request. The rehab director continued that the resident was in agreement with the changes PT put into place. PT further indicated that the therapy department did not unsafely rig things. Resident #77 had a chair that was being delivered and duct taping the anti-tippers was not a long term solution. Modifying the chair was to accommodate Resident #77's request.

Interview with the Administrator on 7/17/14 at 3:24 pm revealed she was unaware that the

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F 323	Continued From page 16 resident had duct tape applied to the named residents anti-tippers. The Administrator further revealed it was her expectation that interventions put into place by the physical therapist are not in violation of the manufacturer's expectations. The administrator continued that manufacturer's recommendations were not available and physical therapy was acting in accordance with the resident's wishes in order to keep her safe.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that staff wear hair nets when entering the kitchen on 2 of 3 kitchen observations. The findings included: During observation of the tray line while food was being prepared on trays at 11:58AM on 7/16/14 housekeeping staff #1 entered the kitchen and approached the tray line to obtain her lunch from the cook. She was not wearing a hair net.	F 371	Corrective Action: No residents were impacted by this alleged practice. Identification of other residents who have the potential to be affected by this practice: All residents may be impacted by this alleged practice. There have been no reports of any health concerns or issues associated with employee entering kitchen without a hair net or obtaining ice from the ice machine. Systemic Changes: Dietary Manager	7/21/14

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F 371	Continued From page 17 An interview with housekeeping staff #1 on 7/16/14 at 12 noon revealed that she never wears a hair net when she enters the kitchen to get her lunch. During a kitchen tour on 7/14/16 at 1:50PM, laundry staff #1 was observed in the kitchen getting ice out of the ice machine for her personal cup. An interview with laundry staff #1 on 7/16/14 at 1:52PM revealed that she comes into the kitchen all the time to get ice and indicated that she never wears a hair net. During an interview with the assistant dietary manager on 7/16/14 at 1:55PM revealed that her expectations were that staff wear a hair net upon entering the kitchen. She further indicated that a sign is posted at the door. The sign states: All staff and visitors picking up their meals must wait at the door and dietary personnel will assist you.	F 371	conducted an inservice with facility staff on 07/16/14 regarding the requirement to wear a hair net at all times when in the kitchen. The sign at the door was repositioned for easier visibility, and a box of hair nets has been affixed to the kitchen door for ease of staff use. Also included was the procedure for non-kitchen staff to ask the dietary staff to obtain ice from the kitchen as needed. Monitoring: To ensure compliance, the Dietary Manager or her designee will monitor using the QA survey tool the kitchen to ensure proper use of hair nets and that staff properly asks dietary staff to obtain ice from the kitchen. Any instances of non-compliance will be reported to the Administrator or DON. Any staff found to be non-compliant will be re-educated. Repeated violations will be addressed with disciplinary action, and may result in termination of employment. Monitoring will occur at least five times per week for four weeks, then once per month for three months. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.	F 460		8/14/14

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F 460	Continued From page 18 In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and interview with residents the facility provided resident rooms with privacy curtains that did not extended all the way around the bed to provide full visual privacy. The facility failed to have privacy curtain hooks that were functioning and flowed smoothing within the tracks. The facility failed to install tracks to ensure full visual privacy. This was evident in 3 of 3 resident care units. (Units 100, 200, and 300) Findings included: A, Observation of the environment on 7/16/14 at 9:31 am through 10:40 am with the maintenance director was conducted. During the observation the maintenance director measured the gaps of insufficient privacy curtains. These observations revealed the privacy curtains would not completely provide full visual privacy as noted below: In Room 110 B there were insufficient privacy curtains which created a 94 inch (") gap. In Room 109 B there were insufficient curtains which created a 21 " gap. In Room 107 A the privacy curtains were double hung and created a 77 " gap around the resident ' s bed. In Room 107 B there were insufficient curtains which created a gap of 59 " . In Room 121 B there were insufficient curtains	F 460	Corrective Action: Privacy curtains for rooms 110, 109, 107, 121, 108, 125, 104, 122, 208, 209, 316, 105, 211, 301, 100 and 124 were replaced or repaired as needed on 07/17/14. The residents in room 100 are a married couple. Privacy curtain tracks were installed by the Maintenance Director on 07/16/14. Identification of other residents who have the potential to be affected by this practice: All residents have the potential to be affected by this alleged practice. On 07/24/14 Housekeeping Supervisor completed audit on the remaining resident rooms to ensure that full visual privacy is afforded. Nine rooms were identified, with curtains being replaced or repaired as needed. Systemic Changes: Housekeeping staff were inserviced on 08/09/14 by the Housekeeping Supervisor regarding the expectation that all residents are afforded full visual privacy. In addition for checking for cleanliness, Housekeepers are to check privacy curtains while cleaning rooms to ensure that they meet this requirement.	

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F 460	Continued From page 19 which created a gap of 59 " . The netting portion of the privacy curtains had 3 holes measuring 9 " , 9.5 " and 5 " respectively. In Room 108 B there were insufficient curtains which created a gap of 62 " . In Room 125 B there was 36 " of insufficient curtains. In Room 104 B there was 94 " gap of insufficient privacy curtains. There was a 5 inch hole in the netting of the privacy curtain. In Room 122 there were insufficient curtains creating a 70 " gap. There was a hung mirror in front of the bed attached to the bathroom door. The mirror measured 29 " tall and 13 1/2 " width. The resident in B bed can be seen from the A bed when the curtains are not drawn fully around the resident. Interview during the observation with Resident #7 revealed " I would be embarrassed if someone was to see me exposed. " In room 208 B there was insufficient curtains which created a 53 " gap. In room 209 B there were 2 holes in the netting. In room 316 B there were insufficient privacy curtains which created a 97 " gap. Interview on 7/16/17 at 10:40 am with Resident #145 revealed it bothers her not to have privacy because we do not have much here. No other explanation was provided. B. Observation of the environment on 7/16/14 at 9:31 am through 10:40 am with the maintenance director was conducted. During the observation the maintenance director measured the gaps of insufficient privacy curtains. These observations revealed the hooks to the privacy curtains became stuck or would not flow freely within the tracks to provide full visual privacy as noted below:. Some of the hooks attached to the privacy	F 460	Monitoring: To ensure compliance, the Housekeeping Supervisor will conduct a review of privacy curtains for three residents, using the QA Survey Tool. Monitoring will occur five times per week for four weeks, then will continue once per month for three months. Any issues identified will be corrected immediately by Environmental Services Staff and reported to the Administrator or DON. If corrections cannot be made immediately, residents will be temporarily moved to a room affording full visual privacy until repairs can be completed. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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curtains in Room 109A broke off when touched. Other hooks became stuck and some hooks came out of the tracks when pulled which did not provide full visible privacy.
In Room 105 B the hooks became stuck in the tracks and would not move. This created a 50 " gap of insufficient curtains.
In Room 211A the hooks were not attached to the privacy curtains.
In Room 301 B the hooks would not flow smoothly through the tracks when stuck created a 60 " gap. Interview during the observation with Resident # 54 revealed without the curtain we have no privacy if someone walks in. Resident #54 indicated it would be nice to have more curtains. Interview on 7/16/14 at 10:30 am with (nursing assistant) NA #4 revealed when she cares for this resident she would close the window blinds and does not use any other privacy device.
In Room 316 A hooks will not flow freely in the tracks which created a 25 inch gap.
In Room 124 B hooks of the privacy curtain were stuck in the tracks and would not freely move when NA #3 attempted to provide privacy for the resident on 7/15/14 at 1:53 pm.

C. Observation of the environment on 7/16/14 at 9:31 am through 10:40 am with the maintenance director was conducted. These observations revealed:
· In Room 100 there was no track for the curtains to be hung. Interview with Resident #101 at the time of the observation revealed there had not been a track installed for the curtains to be hung for a long time (unsure of what long time).
· In Room 124 A the privacy track attached to the ceiling went across the middle of the resident's bed and not installed to go around the

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F 460	Continued From page 21 entire bed for full visible privacy. This was observed initially on 7/15/14 at 1:53 pm. Interview with Resident #25 on 7/15/14 at 1:53 pm revealed the tracks had been this way since her admission to the room. Interview on 7/16/14 at 10:50 am with the housekeeping supervisor (HK) revealed her staff was responsible for checking privacy curtains every day for cleanliness. The HK indicated that her staff do not check whether there was sufficient privacy curtains or whether the hooks were functional. Observations on 7/16/17 after the interview with HK revealed housekeeping staff were noted to be removing insufficient privacy curtains and replacing sufficient curtains from the above rooms. Observations on 7/17/14 at 11:15 am and 3 PM revealed housekeeping staff again noted to be removing and replacing privacy curtains. Interview on 7/17/14 at 4:14 pm with the administrator revealed her expectations were to afford each resident dignity and privacy.	F 460		